Youth Ministry Medical Information Form

Complete this form only if medication is to be administered during youth ministry programs.

YOUTH INFORMATION

NAME (FIRST, LAST)

BIRTHDATE GENDER AGE

PROGRAM(S) RACE GRADE

PARENT/GUARDIAN(S) INFORMATION

NAME PRIMARY PHONE

WORK PHONE SECONDARY PHONE

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WORK PHONE SECONDARY PHONE

MEDICATION GUIDELINES

Medications must be dropped off and picked up each day by a guardian or authorized adult. Any medications left overnight for the registered session will be documented in the centrally stored medication log. All medications are stored in locked containers in a locked cabinet. Medications will be administered by designated health supervisors. ***Only medications in their original package with prescription labels are accepted.***

PHYSICIAN INFORMATION

PHYSICIAN'S NAME ______________________________

PHONE ______________________________

HOSPTIAL ______________________________

SIGNATURE______________________________

DATE ______________________________

MEDICATION INFORMATION

Please fill out one section per medication.

MEDICATION NAME STRENGTH DOSAGE

ADMINISTRATION INSTRUCTIONS *(IE: at mealtime)* STORAGE INSTRUCTIONS

QUANTITY SENT TO CAMP QUANTITY PRESCRIBED

DATE PRESCRIBED EXPIRATION DATE PERMANENT TEMPORARY *(List dates)*

REASON FOR MEDICATION

POSSIBLE SIDE EFFECTS *(IE: reaction to food, dehydration, stress, restrictions on activity)*

WHICH, IF ANY, OF THE ABOVE SIDE EFFECTS HAS YOUR CHILD EXPERIENCED?

TO WHAT EXTENT?

OTHER IMPORTANT INFORMATION REGARDING MEDICATION

EXPECTED CONSEQUENCES IF MEDICATION IS NOT TAKEN AS DIRECTED

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PERMISSION TO CARRY AUTHORIZATION

Parent/Guardian(s) may allow their child to carry and administer medications needed for life-threatening conditions such as epi-pens for anaphylactic reactions and asthma inhalers. Prior approval is required for other medications to be carried.

By signing below, the parent/guardian(s) acknowledges that their child has been informed of all pertinent information regarding this medication and has authorized for youth to self-administer as directed.

Parent/Legal Guardian (printed) ____

Signature____________________________________ Date ________________

By signing below, the child acknowledges that she/he fully understands the purpose for and administration of the above mentioned medication.

Youth's Name (printed) ____

Youth's Signature________________________________ Date ________________